Community Services Reimbursement Rate Commission

ANNUAL REPORT

Executive Summary

January 2004

CONTENTS

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

Theodore N. Giovanis, FHFMA, M.B.A., Chairman
Alan C. Lovell, Ph.D., Vice Chairman
Jerry Lymas, B.A., J.D.
John Plaskon, B.S., M.S.
Queenie Plater, B.S., M.S.
Lori Somerville, B.S., M.S.

(Note: Biographical sketches are included as Appendix A.)

Community Services Reimbursement Rate Commission
11141 Georgia Avenue, Suite 517
Wheaton, Maryland 20902-4680

301-946-9790
800-646-7332
240-248-0057 FAX
CSRRC@aol.com
http:\\www.dhmh.state.md.us\csrrc

This report, and the appendices to the report, can be downloaded from the Commission website.

Administrative and data consultant:

REDA International, Inc.
11141 Georgia Avenue, Suite 517
Wheaton, Maryland 20902-4680

301-946-9790
800-646-7332

Technical consultant:

J. Graham Atkinson, D.Phil.
1449 44th Street, NW
Washington DC 20007-2002

202 338 6867
JGAtkinson@aol.com

REPORTING REQUIREMENTS

On or before October 1 of each year the Commission shall issue a Report to the Governor, the Secretary, and, subject to paragraph 2-1246 of the State Government Article, the General Assembly that:

1. Describes its findings regarding:

(I) The relationship of changes in wages paid by providers to changes in rates paid by the Department;

(II) The financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(III) The incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration and how the methodologies might be improved;

(IV) How incentives to provide quality of care can be built into a rate setting methodology; and

(V) The recommended methodologies for the calculation of rate update factors and the rate update factors recommended for the next succeeding fiscal year.

2. Recommends the need for any formal executive, judicial, or legislative actions;

3. Describes issues in need of future study by the Commission; and,

4. Discusses any other matter that relates to the purposes of the Commission under this subtitle.

In addition, in the report due on or before October 1, 2002 and October 1, 2005 the Commission shall include its findings regarding the extent and amount of uncompensated care delivered by providers.

Executive Summary

The State of Maryland desires an environment for citizens with developmental disabilities and mental illness that ensures quality, equity, and access to services and financial resources. The Commission believes that the State is committed to a system that provides quality care and that is fair to efficient and effective providers. As the human services and health care markets change and as changing demands are placed on the providers of services, it is important to ensure the continued successful operation of providers within a reasonable budgetary framework.

The Commission was established by the Maryland legislature in 1996, so has been in operation for 8 years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the eighth such Annual Report. The Commission consists of 7 members, appointed by the Governor, and with the advice and consent of the Senate.

Through July 1999 the Community Services Reimbursement Rate Commission (CSRRC) met monthly to address its charges as outlined in Senate Bill 685 (1996). These charges were modified by Senate Bill 448 (1999) and further by House Bill 454 (2002). At the July 1999 meeting the Commission decided that it would be more productive to establish Technical Advisory Groups (TAG) and to replace two thirds of the formal Commission meetings with TAG meetings. The first set of TAG meetings was held in August 1999, and this structure has proved to be quite productive so the Commission has continued to use it. The topics covered in the TAG meetings have included:

- Design of wage surveys to collect wage rate and staff turnover information from providers, and the interpretation of the data collected by these surveys;
- The definition of uncompensated care, and the design of surveys to collect data on uncompensated care and related issues from providers, and the interpretation of the results of these surveys;
- The financial condition of the providers;
- The structure of updating systems; and,
- The measurement of quality and outcomes, and how incentives to improve quality can be built into the payment system.

As a result of the Commission's concern about quality of care the December 4, 2000 meeting was devoted to quality issues in services for individuals with developmental disabilities, and the January 8, 2001 meeting to quality issues in mental health services, with presentations by invited speakers and discussions with providers. A paper discussing quality measurement and how to build incentives for quality into the payment system was prepared and included in the 2002 Annual Report.

Staff has prepared several briefing and issue papers, some of which are attached in Appendix B of the report. This report also offers the Commission's observations with regard to funding and payment methodology, the adequacy of the rates and rate updates, new system transitions, social policy, provider efficiency, and quality and outcomes. The Commission remains committed to providing constructive recommendations to the Governor, the General Assembly, and the Secretary

in a timely manner. It should be noted that the recommendations have been developed in a balanced manner; the report should thus be considered as a unit rather than as a set of individual recommendations.

Key findings from the past year include the following:

- Neither the DDA nor the MHA payment systems include systematic mechanisms to adjust rates for inflation and other factors. Such adjustment mechanisms should be developed and implemented. The Commission has designed a suitable system, and calculated the update factor that would result from its application.

- The salary levels paid by DDA providers and in a number of MHA community service employment categories are lower than the corresponding salaries of State employees, particularly when fringe benefits are taken into account.

- The wage increases given by the providers to direct care workers have exceeded or equaled the rate increases they have received.

- The collection of uniform data on an ongoing basis is needed to monitor, compare, and evaluate the present and new payment systems in the context of the Commission's statutory authority as well as DDA and MHA responsibilities to monitor the system. The data submission from the DDA providers has substantially improved in the past two years, but the data from the MHA providers is still inadequate.

- The measurement of quality of services and of outcomes are still at a developmental stage. It would be premature to base payments on specific measurements of quality and outcomes.

- The psychiatric rehabilitation providers paid by MHA and the providers paid by DDA have increased the wages for direct care workers over the past three years by more than the change in the rates they have received from MHA and DDA, respectively.

Both MHA and DDA have promulgated regulations requiring the submission of wage surveys and other data. The data that will be submitted pursuant to these regulations is expected to greatly assist the Commission in its analyses.

Social Policy Choices

The context in which social policy choices are made needs to be examined. For example, historically there have been lists of clients waiting to receive services, and providers are requesting higher rates to care for existing consumers and to make investments in quality. It was anticipated that, for DDA, this conflict between improving services to existing clients versus serving more clients would begin to be resolved by the Governor's waiting list reduction initiative. However, the waiting lists appear to be increasing again.

In the mid-1990s the public mental health system was expanded to serve more individuals without Medicaid who are eligible for public subsidies for selected services, but without a commensurate increase in the overall budget. Between 1998 and 2003 the number of individuals served increased

by 40%. As would be expected, MHA experienced budget shortfalls. MHA is now responding to ongoing budget overruns by cutting back on gray area eligibility and limiting rehabilitation services for gray area and Medicaid eligible adults and children. Choices such as covering new clients, dropping clients from coverage, or ensuring stability for existing providers need to be made consciously. MHA has described the context for its decision making in the values set forth in its 5-year plans. DDA's planning efforts are directed by the goals of its self-determination project and its waiting list initiative.

The Commission will continue to look into these issues in the coming year.

The Financial Condition of the Providers

In considering the results reported here it should be kept in mind that our assessment of the financial condition of the providers is based on available data, which often involves a lag of more than a year. The bulk of the psychiatric rehabilitation providers contracting with MHA appear to be in a stable financial situation although that may change with the budget cuts being made in FY 2004. Many rehabilitation providers are anticipating cuts of 10% or more in revenues. Several providers have closed programs for children and adolescents due to financial pressures. The majority of the providers contracting with DDA have a positive margin, but the mean margin dropped to about 1% in fiscal year 2001, and recovered slightly in 2002. Many of the outpatient mental health clinics (OMHC) are losing money, and have cash flow problems. Their situation is sufficiently serious that access to care could be threatened in some areas of the state. The financial condition of the OMHCs will be exacerbated by reductions in gray area eligibility, and by reductions in Medicare payments rates. The Commission intends to study the changes being made in the MHA fee schedule to make it HIPAA compliant, and the effects of these changes on the financial condition of the providers.

In accordance with the legislative requirement to assess "the financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest," the Commission intends to maintain a close watch on the financial condition of the providers by obtaining updated information as soon as it becomes available, replicating the analyses reported here, and reporting the results in interim work papers.

Recommendations

Separate sets of recommendations are being made for MHA and for DDA related issues, although there is overlap between these two sets of recommendations. These recommendations are listed in priority order.

CSRRC Recommendations pertaining to MHA

1. **The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.**

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the legislature the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor. These recommendations should be implemented.

Some of the community services rates paid by MHA were increased in fiscal years 1999, 2000 and 2003. However, the MHA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and DHMH has an updating system for the rates paid for medical day care. Such systems can be quite simple or relatively complex.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems.

The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The Commission continues to be concerned about specific rates, for example, the PRP rates for children given the large amount of service coordination they require. MHA does pay a higher rate for children's OMHC services, so the question there is whether that differential is sufficient to account for the higher staffing and/or greater amount of coordination that is required when providing

services to children. PRP's do not receive a higher rate for services to children, although greater coordination is also required in that setting.

The Commission recently received comments from MHA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

2. MHA should require the annual submission of audited financial reports[1] and should have the authority to apply financial sanctions against providers who fail to submit required reports.

Weak financial performance can impact on access to services, and the provision of quality services. Thus, it is important for MHA and the Commission to track the financial condition of the providers in a timely manner, and to respond if the financial condition looks weak. The ability to do this is restricted by the lack of availability of financial statements. To date the Commission's analysis has relied on an incomplete sample of audited financial reports gleaned from a variety of sources, MHA audit division records, CBH records, and the CSAs. This has limited the ability to draw conclusions, and made the reports much less timely than would be desirable.

Having an almost complete set of audited financial reports available in a reasonably timely manner would allow the Commission, and MHA, to assess the financial condition of the providers in general, and also to identify providers with particular problems, for whom a focused intervention might be required. This will aid in planning for changes to alleviate problems, and avoid unexpected closures of providers, which could potentially result in access problems. Once the Commission sunsets it will be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers.

3. The Commission supports the concept, currently being explored by MHA, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care.

MHA is considering paying monthly case rates for selected packages of services. A change to an appropriately sized rate could provide more flexibility to providers in their provision of services, while at the same time reducing administrative costs for pre-authorization of services, both for the providers and the administration. However, paying for bundles of services can provide a financial incentive to underserve, so appropriate safeguards should be built into the reporting systems to monitor levels of services when such changes are made.

When the Commission started operations one of its first tasks was to examine the incentive structure of the payment system. At that time the issue of capitation or case rates was broached. While such payment mechanisms can provide additional flexibility to providers in how they provider services, neither the financial data or the quality monitoring mechanisms then available were considered adequate to accurately determine the appropriate case/capitation rates or to protect against potential underservice. In the interim MHA has gained experience in case rate/capitation payment systems with its ongoing demonstration with Baltimore Mental Health System, and its information

[1] Or an unaudited report with equivalent data if the provider does not have an audited financial report.

monitoring capabilities have vastly expanded through Maryland Health Partners. The time is now ripe to proceed with expansion of the use of case and/or capitation payment systems for selected services.

Commission Recommendations pertaining to DDA

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers and have only been applied to the wage and salary component of the provider costs. The providers have, thus, not been recompensed for inflation on other components of their costs. However, there is no systematic approach to providing rate increases to the providers. Additionally, the weights used to calculate the Fee Payment System (FPS) payment have not been updated. If the weights are no longer appropriate, this could result in under- or overpayment for services. Consequently, underfunding could be confused with problems in the FPS payment methodology.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and DHMH has an updating system for the rates paid for medical day care. Such systems can be relatively simple or quite complex.

The community services budget of DDA was increased in most fiscal years, partly for rate increases and partly because the number of people served has increased. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues. In addition, a systematic approach to the updating of rates is the only way to ensure the long term viability of these services.

DDA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

The change in rates developed through the updating system should be taken into account in the development of the DDA budget.

The Commission has recently received comments from DDA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

2. The legislature should preserve the additional funds to be provided to increase the wages and fringe benefits being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates and the level of fringe benefits of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, remain substantially below the wages and fringe benefits paid to corresponding state workers.

The legislature, in the DDA budget language, required DDA to develop a plan to provide additional funds to the providers, with the goal of increasing the wages and fringe benefits being paid to direct care workers. The Commission believes that it is important to continue with the planned rate increases when quantified by DDA.

The Commission's most recent analysis of the financial condition of the providers shows a weak and deteriorating financial condition. The median margin dropped from about 3.2% in FY 2000 to about 0.7% in FY 2001 and increased slightly to 1.3% in FY 2002. Over the past several years the providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

3. Additional requirements should be put in place to ensure the consistency of the wage and benefit information being submitted by the providers in response to the annual wage and salary survey.

The wage and fringe benefit information submitted by the providers is essential for monitoring the progress of the wage equalization initiative, and in observing whether the additional funds provided by DDA are being used for the purposes for which the funds were intended. Comparison of the data submitted by the providers in recent surveys suggests that there are inconsistencies in the way in which these data are being reported between years. The Commission staff and DDA have discussed these inconsistencies, and the need for additional validation of the data. Additional reviews should be implemented to allow for the required verification.

For its part, the Commission will work with DDA and MACS to improve the instructions for the wage survey, and will provide one or more training sessions on the importance of the survey information, the purposes for which the surveys are used, and how the data should be reported.

Commission Activities

Commission meetings and Technical Advisory Group (TAG) meetings are generally held the first Monday of each month unless that is a holiday. Commission meetings generally run from 1 p.m. to 3 p.m. The Mental Hygiene Administration TAG meetings runs from 1 p.m. to 3 p.m. and the Developmental Disabilities Administration TAG meetings from 3 p.m. to 5 p.m. The meetings are held at:

The Meeting House
Oakland Mills Interfaith Center
5885 Robert Oliver Place
Columbia, Maryland

Commission meetings were held on, or are scheduled for, the following dates:

January 6, 2003
April 7, 2003
September 8, 2003
December 1, 2003
January 5, 2004
April 5, 2004
September 13, 2004
December 6, 2004

Technical Advisory Group meetings were held on, or are scheduled for:

February 3, 2003
March 3, 2003
May 5, 2003
June 2, 2003
August 4, 2003
October 6, 2003
November 3, 2003
February 2, 2004
March 1, 2004
May 3, 2004
June 7, 2004
August 2, 2004
October 4, 2004
November 1, 2004

APPENDIX A

Biographical Sketches of Community Services Reimbursement Rate Commission Members

Theodore N. Giovanis, FHFMA, M.B.A.
Theodore Giovanis is President of T. Giovanis & Company, a consulting firm specializing in legislative, regulatory, and strategic consulting with an emphasis on health care policy. He has served as a technical resource for congressional staffs and the Administration. In addition to extensive consultant experience in health care financing, regulation, and policy, he has served as Director of the Health Care Industry Services of Deloitte & Touche, Director for Regulatory Issues of the Healthcare Financial Management Association, and Assistant Chief of the Maryland Health Services Cost Review Commission.

Mr. Giovanis received an M.B.A. in management from The University of Baltimore and is a fellow in the Healthcare Financial Management Association (HFMA). He is also certified in managed care.

Alan C. Lovell, Ph.D.

Alan C. Lovell is currently the Chief Executive Officer of CHI Centers, Inc., "supporting people with disabilities since 1948," a multi-purpose, community-based organization serving children and adults with disabilities. He has served in numerous leadership positions, including President and Chair with the Maryland Association of Community Services, the Maryland State Developmental Disabilities Council and the Montgomery County Interagency Coordinating Committee for People with Developmental Disabilities (InterACC/DD).

Dr. Lovell received his Ph.D. in public administration from Kensington University.

Jerry Lymas, B.A., J.D.

Jerry Lymas is currently the President of the Justin Development Group, Inc., a Neighborhood development firm specializing in neighborhood real estate development, construction management, facilities management, and development for churches through the Justin Development Group 50 Churches 50 Corners Program. Prior to that he was Special Assistant to The Honorable Parren J. Mitchell on matters relating to housing and development. He served in the U.S. Army, reaching the rank of First Lieutenant.

Mr. Lymas received his B.A. from Morgan State University in history, and his J.D. from the University of South Carolina Law School.

Queenie C. Plater, B.S., M.S.

Queenie Plater is currently the Director of Employment and Employee Relations at Sibley Hospital in Washington, D.C.. Ms. Plater has held a few position in Human Resources at Sibley during the past 12 years. Her experience ranges from recruitment and retention, benefits, through compensation and employee relations. As EEO Officer at the hospital she represents the hospital at hearings and advises managers on policy interpretation and administration.

Ms. Plater received her B.S. in Organizational Management from Columbia Union College, and her M.S. in Applied Behavioral Science from Johns Hopkins University.

John Plaskon, B.S., M.S.

John Plaskon is currently the Executive Director of Crossroads Community, Inc., a position he has occupied for 13 years. He also serves on the Boards of The Maryland Association of Non-Profit Organizations, The Upper Shore Community Mental Health Center, Shore Leadership, and the Queen Anne's County Local Management Board. Previous experience includes having been a Developmental Disabilities Coordinator on the Eastern Shore, Program Director for Channel Marker, and a Rehabilitation Counselor in New Jersey.

Mr. Plaskon received his B.S. in meteorology from Rutgers University , and an M.S. in educational psychology from Texas A&M, as well as a certificate in administrative practice from UMBC.

Lori Somerville, B.S., M.S.

Lori Somerville is currently the Chief Operating Officer of Humanim. Humanim is a private, non-profit organization that provides clinical, residential, and vocational services to children and adults with disabilities. Prior to serving as COO, Lori served as the Director of Human Resources. She came to Humanim in 1998 by way of a merger with Vantage Place, a residential program for adults with psychiatric disabilities and adults with brain injuries. Lori had spent fourteen years at Vantage Place and over 6 as the Executive Director. She is a graduate of Leadership Howard County and currently serves on the board of Children of Separation and Divorce. Lori's previous experience includes serving on the Community Behavioral Health Association Board of Directors and serving as President of the Association of Community Services and Supported Living Boards.

Lori received her undergraduate degree from Towson State in Psychology and a Master's from Johns Hopkins in Organizational Development.